

BEHAVIORAL OBSERVATIONS
(Check all Relevant Categories)

<input type="checkbox"/> Aggressive	<input type="checkbox"/> Irrational	<input type="checkbox"/> Passive
<input type="checkbox"/> Agitated	<input type="checkbox"/> Labile	<input checked="" type="checkbox"/> Withdrawn
<input type="checkbox"/> Delusional	<input type="checkbox"/> Lethargic	<input type="checkbox"/> Terrified/Crying
<input checked="" type="checkbox"/> Eye Contact Poor	<input type="checkbox"/> Loose Associations	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Hallucinating	<input type="checkbox"/> Manipulative	
<input type="checkbox"/> Hyperactivity	<input type="checkbox"/> Paranoia	

Comments:

MENTAL STATUS EXAMINATION
(Write in Brief Description)

Affect: Flat	Appearance: well groomed
Concentration: average	Intellectual Functioning: average
Mood: depressed	Memory: poor
Orientation: x4	Speech: slow, soft
Other:	

SUICIDE POTENTIAL SCREENING

1. Correctional or Transporting Officer reports inmate may be suicidal risk.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
2. Experienced a significant loss within last six months. Describe: _____	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
3. Worried about major problems other than legal situation. Describe: Refuses to Say	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
4. Holds position of respect in community and/or alleged crime is shocking in nature.	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. First involvement with legal system. Describe: _____	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
6. Appears to feel unusually embarrassed or ashamed.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
7. Expresses feelings of helplessness or hopelessness.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
8. Shows signs of depression: crying, emotional flatness Describe: _____	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
9. Appears overly anxious, afraid, or angry.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10. Is acting and/or talking in a strange manner. (cannot focus attention, hallucinating)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

SUICIDE POTENTIAL SCREENING (continued)		
11. Has made previous suicide attempts.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Date of most Recent Attempt: <u>1999</u>	Method: <u>Cut self</u>	
Number: <u>4±</u>		
12. Expresses thoughts of killing self.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
13. Has a suicide plan.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Describe: _____		
14. Has the means to carry out the suicide plan.	<input checked="" type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. Family member or significant other has attempted or committed suicide.	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Relationship: <u>Best Friend</u>		
Date: <u>When we 7th grade</u>	Method: <u>Guns</u>	
TOTAL YES/NO COUNT		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

If there are any checks in the Behavioral Observation Section (pg. 1), or if the total yes count in Suicide Potential Screening

DISPOSITION

(check all appropriate boxes)

- Place on continuous suicide watch
- Place on close suicide watch
- Psychiatric medication order needed

REFERRAL FOR MENTAL HEALTH EVALUATION:

(check one box)

- Emergency referral (1 hr)
- ASAP referral (3 days)
- Routine referral (30 days)
- No referral

(check one box)

- Place in crisis/safe cell
- Place in special housing
- Place in RTU
- Place in general population

Comments:

Mental Health
Classification Assigned

- N
- C₁
- C₂
- C₃

Inmate Name: u mark

Number: 379-889



Case 1:00-cv-00803-SAS-TSB Document 79-10 Filed 12/05/2005 Page 3 of 23
Initial Medical/Mental Health/Substance Use Screening

Provide information in the *Comments* section for all questions answered yes.
All information is based upon self report of inmate.

Date of Interview:	11-28-99	Signature/Title of Interviewer:	P. Nicastro RN BSN
Time of Interview:	900 pm	Institution:	TCI
Printed Name/Title of Interviewer:	Pat Nicastro RN		
Date of Arrival at Institution:	2 mos. ago	Time of Arrival at Institution:	_____
Received from:	Lucasville		
Inmate Name:	Woods, Bruce		
Inmate Number:	329 889		

1 <input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	History of outpatient mental health treatment
2 <input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	History of inpatient treatment
3 <input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	History of head injury
4 <input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	History of violent behavior
5 <input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	History of suicide attempts**
6 <input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Current suicidal thoughts**
7 <input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Current suicide plan**
8 <input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Ability to carry out current suicide plan**
9 <input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	Unusual behavior/affect**
10 <input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Current psychotropic medications (see current medication on medical form)
11 <input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Hallucinations** in past at age 12-13
12 <input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Was this inmate on caseload at sending institution. If discharged, give date:

Yes responded to items with ** should be referred for either immediate attention or evaluation as dictated by the individual circumstances.

Comments:

Yes No Mental health orientation information given to inmate
MENTAL HEALTH DISPOSITION (Check one or more)

<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Crisis/Safe cell assignment requested
<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	Special housing assignment requested
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Routine housing requested
<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	Emergency mental health referral

MEDICAL DISPOSITION

<input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Special Needs Unit	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Emergency Transport
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Infirmary Admission	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Routine Housing
<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	Physical Referral			

SUBSTANCE USE SCREENING

<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	History of alcohol and drug problem.
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Previous alcohol and drug treatment.
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	History of alcohol and drug problem when ceasing use.

	Date of Last Use	Method	Frequency
Alcohol	<i>11-28-99</i>		
Amphetamines	<i>11-28-99</i>		
Cannabis	<i>11-28-99</i>		
Cocaine	<i>11-28-99</i>		
Hallucinogens	<i>11-28-99</i>		
Inhalants	<i>11-28-99</i>		
Nicotine	<i>11-28-99</i>		
Opiates	<i>11-28-99</i>		
Phencyclidine	<i>11-28-99</i>		
Sedatives	<i>11-28-99</i>		

Frequency of Use Codes:

- 1 = Less than 12 times yearly
- 2 = Once per month
- 3 = Twice per month
- 4 = Once per week
- 5 = 2 times per week
- 6 = More than 3 times per week
- 7 = Daily
- 8 = Binge

Method of Administration Coding:

- 1 = Oral
- 2 = Intravenous
- 3 = Subcutaneous
- 4 = Inhalation
- 5 = Intranasal
- 6 = Smoking
- 7 = Freebase
- 8 = Other

Mental Health Transfer Summary

Inmate Name:	Woods, Bruce	Inmate Number:	329-889
Reason for request:	HOSPITAL RELEASE		
<input type="checkbox"/> Custody: change from	to	<input type="checkbox"/> Mental Health: needs	<input checked="" type="checkbox"/> E&E
<input type="checkbox"/> other		<input type="checkbox"/> Program: needs	<input type="checkbox"/> MAR 13 2000
<input type="checkbox"/> Medical: needs		<input type="checkbox"/> Classification process	<input type="checkbox"/> TO MENTAL HEALTH SERVICES
Current Mental Health level:	<input type="checkbox"/> N	<input checked="" type="checkbox"/> CI	<input type="checkbox"/> C2
Psychiatric medications prescribed:	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> No
Is this transfer outside the cluster:	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> Do not know	

Mental Health Concerns: Watch status within last 10 days:	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Type:
<p><input checked="" type="checkbox"/> Does have at least 3 depression - has made visit to ER at least 3 times in past 12 months & self injury & "going off" in the past (1/1/99) And 2 previous attempts in 1998 (no info on type of attempt).</p>			

Name of person completing report:	Marcelle Bessette, LCS	Signature of person completing report:	Lace	Date:	3/13/00.
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If the transfer involves an inmate on the Mental Health caseload to be transferred to an institution OUTSIDE the cluster, the Bureau of Mental Health Services must approve the transfer.

Approved Denied

Bureau of Mental Health Services

Date: 3/14/00

Axis I: Depressive Disorder NOS.	Current prescribed medication:	Compliance (3 months)									
		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th>3/1/00</th> <th>3/1/00</th> <th>3/1/00</th> </tr> <tr> <td>100%</td> <td>93%</td> <td>98%</td> </tr> <tr> <td></td> <td></td> <td></td> </tr> </table>	3/1/00	3/1/00	3/1/00	100%	93%	98%			
3/1/00	3/1/00	3/1/00									
100%	93%	98%									
Axis II: Delinquent											
Axis III: None											

Changed in last month: Yes No

Housing recommendations:	
Current mental status and summary of progress in treatment:	
<p><input checked="" type="checkbox"/> Stable at this time. less depressed & compliant w/ current meds.</p> <p>If transferred - should be transferred to another FSD.</p> <p><input checked="" type="checkbox"/> Does not attend any groups - would benefit from groups & individual counseling along w/ medication.</p>	
Signature of person completing this section:	Lace

WHITE - Standardized with formular required by Bureau of Classification
DRG 6100 (Part 8700)

CASWRY - File in Incident Mental Health file in "Screening/Evaluation/Assessment" section

Mental Health Transfer Summary

Inmate Name:	Woods, Bruce	Inmate Number:	329-889	Room:	TCI
					Date:
					3-28-2000

Reason for request:

Custody: change from _____ to _____

Mental Health: needs _____

other HARDSHIP TRANSFER

Program: needs _____

Medical: needs _____

Classification process

Current Mental Health level:

N C1 C2 C3

Yes No

Psychiatric medications prescribed:

Yes No Do not know

Is this transfer outside the cluster:

Mental Health Concerns: Watch status within last 10 days: Yes No Type: _____
 Has history of Depression. Several months ago made threats of self-injury
 & "going off." Had 2 previous "attempts" reported, in 1990.

Name of person completing report:	A. Michael Ricciardi, Ph.D.	Signature of person completing report:	A. Michael Ricciardi, Ph.D.	Date:	3-28-2000
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If the transfer involves an inmate on the Mental Health caseload to be transferred to an institution OUTSIDE the cluster, the Bureau of Mental Health Services must approve the transfer.

Approved Denied

Bureau of Mental Health Services:	Chris Brown	Date:	3/28/00
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State of Ohio
Department of
Rehabilitation and Correction
**Intrasytem Transfer
and Receiving**
HEALTH SCREENING FORM

Name:	Woods, Bruce	
Number:	329-889	
Date of Birth:	10-18-66	
Race:	B	Sex: M

Date: 4/18/00	Time: 1915	Transferring Institution: SOCF		
Diagnosis: 1 2 3 4		Medications: 1 Paxil 20mg 8HS 2 3 4		
Allergies:		PPD mm: PPD Date: Tetanus date:		
Current Treatments:		Diets:		
Pending Consults:		Chronic Care Clinics:		
Follow-Up Care Needed:				
Disabilities, Limitations, Prosthetic Devices:				
Presently on Suicide Watch? <input type="checkbox"/> Yes <input type="checkbox"/> No		History of Suicide Attempts? <input type="checkbox"/> Yes <input type="checkbox"/> No Date:		
On Psychotropic medications? <input type="checkbox"/> Yes <input type="checkbox"/> No		Signature:		
Date: 4/18/00	Time:	Receiving Institution: WCI		
SUBJECTIVE Complaints:				
Diagnosis: 1 Mental health hb. 2 3 4		Medications: 1 PAXIL 20mg 8HS 2 3 4		
OBJECTIVE: Physical Appearance, Behavior:				
vital signs: Temp: 98.8	Pulse: 84	Resp: 16	BP: 110/70	Weight: 170
ASSESSMENT:				
PLAN (Disposition):	<input type="checkbox"/> Routine (Advised how to access Health Care)		<input type="checkbox"/> DSC Appointment Date:	
<input type="checkbox"/> Pending Consults noted:	None		<input type="checkbox"/> Chronic Care Clinic appointment date: None	
<input type="checkbox"/> Placed in infirmary	<input type="checkbox"/> Special housing	<input type="checkbox"/> Therapeutic diet ordered		<input type="checkbox"/> Work/program limitations ordered
<input type="checkbox"/> Health Education Material Reviewed		Signature: S. Wolfe		

Intrasytem Transfer and Receiving Form



Initial Medical/Mental Health/Substance Use Screening

Provide information in the Comment section for all questions answered yes.
All information is based upon self report of inmate.

Date of Interview:	Signature/Title of Interviewer:	
Time of Interview:	Institution:	Printed Name/Title of Interviewer:
Date of Arrival at Institution:	Time of Arrival at Institution:	Received from:
Inmate Name:	Inmate Number: <i>Wendy Blue 324-887</i>	

1	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	History of outpatient mental health treatment
2	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	History of inpatient treatment
3	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	History of head injury 1975 hit E baseball bat.
4	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	History of violent behavior
5	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	History of suicide attempts** 1999 cut wrists
6	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Current suicidal thoughts**
7	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Current suicide plan**
8	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ability to carry out current suicide plan**
9	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Unusual behavior/affect**
10	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Current psychotropic medications (see current medication on medical form)
11	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hallucinations**
12	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was this inmate on caseload at sending institution. If discharged, give date:

Yes responded to items with ** should be referred for either immediate attention or evaluation as dictated by the individual circumstances.

Comments:

Yes No Mental health orientation information given to inmate
MENTAL HEALTH DISPOSITION (Check one or more)

1	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Crisis/Safe cell assignment requested
2	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Special housing assignment requested
3	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	Routine housing requested
4	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Emergency mental health referral

MEDICAL DISPOSITION

1	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Special Needs Unit
2	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Infirmary Admission
3	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Physical Referral
	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Emergency Transport
	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	Routine Housing

SUBSTANCE USE SCREENING

1	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	History of alcohol and drug problem.
2	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Previous alcohol and drug treatment.
3	<input type="checkbox"/> Yes	<input type="checkbox"/> No	History of alcohol and drug problem when ceasing use.

		<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Date of Last Use	Method	Frequency
Alcohol						
Amphetamines						
Cannabis						
Cocaine						
Hallucinogens						
Inhalants						
Nicotine						
Opiates						
Phencyclidine						
Sedatives						

Frequency of Use Codes:

- 1 = Less than 12 times yearly
- 2 = Once per month
- 3 = Twice per month
- 4 = Once per week
- 5 = 2 times per week
- 6 = More than 3 times per week
- 7 = Daily
- 8 = Binge

Method of Administration Coding:

- 1 = Oral
- 2 = Intravenous
- 3 = Subcutaneous
- 4 = Inhalation
- 5 = Intranasal
- 6 = Smoking
- 7 = Freebase
- 8 = Other

DETAILED MENTAL HEALTH SCREENING FORM

MENTAL HEALTH HISTORY

1.	History of psychotropic medications Current usage List Medications _____ Evidence of EPS _____	Yes <input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/>
2.	History of psychiatric hospitalization	Yes <input type="radio"/> No <input checked="" type="radio"/>
3.	History of out-patient mental health treatment	Yes <input type="radio"/> No <input checked="" type="radio"/>
4.	History of violence: (circle those that apply) Behavior Threats Verbally Assaulitive Physically Assaulitive	Yes <input checked="" type="radio"/> No <input type="radio"/>
5.	History of self-injurious behavior	Yes <input type="radio"/> No <input checked="" type="radio"/>
6.	History of head injury, trauma Describe: _____	Yes <input type="radio"/> No <input checked="" type="radio"/>
7.	Length of time in country jail: _____ Years _____ Months	
8.	History of placement in any special education programs	Yes <input type="radio"/> No <input checked="" type="radio"/>

BEHAVIORAL OBSERVATION
(Circle all Relevant Categories)

Aggressive	Irrational	Passive
Agitated	Labile	Rational
Delusional	Lethargic	Terrified/Crying
Eye Contact	Loose Associations	Withdrawn
Hallucinating	Manipulative	Other _____
Hyperactivity	Paranoia	

MENTAL STATUS EXAMINATION
(Write in Brief Description)

Affect <u>Fugue</u>	Appearance <u>Clean</u>
Concentration <u>Normal</u>	Intellectual Functioning <u>A-</u>
Mood <u>Please see Flat</u>	Memory <u>Total</u>
Orientation <u>X 3</u>	Speech <u>Color</u>
Other _____	

ODRC Health History Available	Yes <input checked="" type="radio"/> No <input type="radio"/>
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Screened By <u>WJ</u>	Title <u>Bob C</u>
Date <u>6/14/91</u>	Time <u>1:22 PM</u>

Reviewed by _____	Title _____
Date _____	Time _____

Inmate Name <u>Ward</u>	Number <u>329-889</u>
Institution <u>EAST</u>	

SUICIDE POTENTIAL SCREENING

1.	Correctional or Transporting Officer reports subject may be suicidal risk.	Yes	<input checked="" type="radio"/> No
2.	Experienced a significant loss within last six months. Describe _____	Yes	<input checked="" type="radio"/> No
3.	Worried about major problems other than legal situation. Describe _____	Yes	<input checked="" type="radio"/> No
4.	Holds position of respect in community and/or alleged crime is shocking in nature.	<input checked="" type="radio"/> Yes	No
5.	First involvement with legal system.	Yes	<input checked="" type="radio"/> No
6.	Appears to feel unusually embarrassed or ashamed.	Yes	<input checked="" type="radio"/> No
7.	Expresses feelings of helplessness or hopelessness.	<input checked="" type="radio"/> Yes	No
8.	Shows signs of depression: crying, emotional flatness Describe _____	<input checked="" type="radio"/> Yes	No
9.	Appears overly anxious, afraid, or angry.	Yes	<input checked="" type="radio"/> No
10.	Is acting and/or talking in a strange manner. (Cannot focus attention, hallucinating)	Yes	<input checked="" type="radio"/> No
11.	Expresses thoughts of killing self.	Yes	<input checked="" type="radio"/> No
12.	Has made previous suicide attempts. Number <u>2</u> Date of Most Recent Attempt <u>9/5</u> Method <u>OB</u>	<input checked="" type="radio"/> Yes	No
13.	Has a suicide plan. Describe _____	Yes	<input checked="" type="radio"/> No
14.	Has the means to carry out the suicide plan.	Yes	<input checked="" type="radio"/> No
15.	Family member or significant other has attempted or committed suicide. Relationship _____ Date _____ Method _____	Yes	<input checked="" type="radio"/> No
TOTAL YES/NO COUNT <u>5/10</u>			

If there are any circles in shaded areas, or if the total yes count is six or more, review for special watch status and refer for mental health evaluation.

DISPOSITION

Approved for general population; no mental health referral

Approved for general population; routine mental health referral

Special Housing - ASAP mental health referral

Suicide precaution procedures - emergency mental health referral

Psychiatric medications order needed

INTER-DISCIPLINARY TREATMENT PLAN
Mental Health Services

Inmate Name: Bruce Woods
DOB: 10/18/1966
Race: Black
EDS Date: / /
Institution Date: 04/18/2000

Inmate #: A-329-889
Gender: Male
MH Level: C2
Original DR&C Date: 06/25/1996
Projected Parole Date: / /

Date of this Plan: 05/11/2000

Next Review Date: 08/11/2000

Axis I: 1. Depressive Disorder NOS 311
 2. Alcohol Abuse 305.00

Axis II: 1. Personality Disorder NOS 301.9
 2. Antisocial Personality Features

Axis III: (No Diagnosis) V71.09

Axis IV: Incarceration

Axis V (Current): 40

Axis V (Highest): 40

Drug(s) of Choice: Alcohol

Therapeutic Assets: Intelligent

Current Psychotropic Medications: Paxil

**Master Treatment Plan, Mental Health Services
Problem Listing Section**

Active PSYCHIATRIC Problems:

Problem #1

Problem Status: Active

PROBLEM: Inmate Woods obtains attention through self-mutilating behavior.

This problem was evidenced by:

1. Reports from non-custody staff
2. Patient's social history
3. Patient's own report
4. Medical history and physical
5. Inter-disciplinary progress notes

GOAL: Inmate Woods will use alternative ways of obtaining attention, other than self-harmful behavior, and will be able to discuss these alternatives in therapeutic sessions.

No.	Objective:	Intervention:	Target Dates:
1A	Inmate Woods will practice positive attention-seeking behavior in the group setting.	Kim Demeter L.S.W. will offer monthly groups where Inmate Woods may receive positive reinforcement for active participation.	08/09/2000
1B	Inmate Woods will be able to describe the effects of his behavior on others and will make short-term (weekly) commitments to change behavior by using problem-solving techniques.	Kim Demeter L.S.W. will provide one 30 min session to focus on behavioral insight, behavior change, and problem-solving skills.	08/09/2000

Discharge Criterion: Inmate Woods will discontinue self-mutilating behavior and will be able to obtain attention in positive and appropriate ways.

**Master Treatment Plan, Mental Health Services
Problem Listing Section**

Problem #2

Problem Status: Active

PROBLEM: Inmate Woods experiences symptoms of depression including , which interfere with his daily life.

This problem was evidenced by:

1. Reports from non-custody staff
2. Patient's own report
3. Inter-disciplinary progress notes

GOAL: Inmate Woods's symptoms will diminish to the point that his daily functioning will no longer be affected, and he will be able to remain in general population housing.

No.	Objective:	Intervention:	Target Dates:
2A	Inmate Woods will be able to accurately state the name, dose, effects and side effects of his medication.	Sagi Raju, M.D. will provide medication to help manage depression with review/ reassessment monthly. Psychiatric Nurse will teach Inmate Woods about the effects of his medicine in at least 1 group or individual session, and will provide compliance counseling as needed.	11/07/2000
2B	Inmate Woods will be able to describe some alternative methods of relieving depression which he may use in addition to medication.	Psychiatric Nurse will teach Inmate Woods about lifestyle choices that may impact mood in Wellness Group, monthly. Kim Demeter L.S.W. will address alternative methods of relieving depression during monthly contact visits.	11/07/2000
2C	Inmate Woods will verbally and/or non-verbally identify and express his emotions, feelings and/or opinions in a healthy manner.	Kim Demeter L.S.W. will address expression of emotions during individual sessions.	08/09/2000

Discharge Criterion: Inmate Woods's objective symptoms will diminish and he will report feeling better.

Master Treatment Plan, Mental Health Services
Problem Listing Section

Patient Agreement:

I have had the opportunity to participate in the development of this mental health treatment plan, and consent to the treatment described herein.

Bruce Woods 329889

Bruce Woods, Inmate
A-329-889

5-17-2000

Date

I agree with this plan, with the following exception(s) :

Signatures of the Interdisciplinary Team:

S. Raju MD

Sagi Raju, M.D., Psychiatrist

Psychiatric Nurse Psychiatric Nurse

Kim Demeter L.S.W.

Kim Demeter L.S.W., Mental Health Liaison

TREATMENT PLAN REVIEW

Notes: (I) afraid of bright, moving colors and cold weather. (I) reports doing "alright" most of the time. Mr. Woods reports that his depression is "bright". (I) denies going outside at present. (I) reports that he was able to watch TV this weekend because he had Mr. Big & Sonja on he thinks about "what it would be like not to be here" - nothing "to be fed". (I) reports that this is not the time to come up with a plan to leave.		Scheduled Review Date: 11/29/99	Date of Review: 11/29/99
Members Present: Righty, S. J., D. J. & D. M.		Scheduled Review Date: 11/30/99	Date of Review: 11/30/99
Notes: (I) not feeling particularly well. (I) is not feeling well, but is taking the correct team. (I) has bilateral (D) headache after him to either psychiatric treat. Because (I) has responsibility for being on the short watch.		Scheduled Review Date: 12/1/99	Date of Review: 12/1/99
Members Present: Righty, S. J., D. J. & D. M.		Scheduled Review Date: 12/1/99	Date of Review: 12/1/99
Notes: (I) reports doing "bright" today. (I) denies going outside at all because of the cold weather. Treatment plan remains the same with treatment 1. No KPI. No chp.		Scheduled Review Date: 12/1/99	Date of Review: 12/1/99
Members Present: Righty, S. J., D. J. & D. M.		Scheduled Review Date: 12/1/99	Date of Review: 12/1/99
		Inmate Name: Woods, Bruce	Inmate Number: 328-889

TREATMENT PLAN

Name: <u>Wolden, Bruce</u>		No: <u>329-889</u>	Treatment Coordinator: <u>R. Clark, M.S.Ed.</u>			
Diagnosis: <u>Depression N.O.S.</u>		Axis IV: <u>Incarceration</u>				
Initial No. <u>1009</u>		Axis V: <u>Custody Staff</u>				
Problem Initiated	Problem	Goals/Objectives	Interventions/Frequency	Responsible	Target Date	Date/Status (A or C or R)
<u>1009</u>	<u>① Depressed & -# at risk for self-harm not suicide attempts</u> <u>X2</u>	<u>① Will manage depressive symptoms</u> <u>minimize suicidal thoughts and report them to mental health staff</u> <u>② Will become active in structure programing to V depression.</u>	<u>① m-H dyad</u> <u>will monitor</u> <u>② Potential for self harm and depression</u> <u>③ group counseling</u> <u>in engage I in structured group activities.</u>	<u>- psych/nurs</u> <u>- psych/nurs</u> <u>- m-H/dior</u>	<u>1/3/2000</u>	
				<input type="checkbox"/> Check here if continued on reverse.		
Signature and Title: <u>S. Kyrd</u>		Signature and Title: <u>R. Clark, M.S.Ed., m-H. staff</u>		Signature and Title: <u>J. Haught, Rd. Ther.</u>		Witness Signature and Title:
Signature and Title: <u>patient Refused to Sign</u>						Date: <u>12-09-01</u>
						Status: <u>A = Admitted</u> <u>C = Contracted</u> <u>R = Refused</u>
						Initials: <u>TK</u>
						Date: <u>12/05/05</u>

participated in the formulation of this treatment plan. Although this is not a legally binding contract, I realize that failure to participate in these activities could result in suspension or removal from specific treatment activities.

TREATMENT PLAN REVIEW

Notes:	<p>Plaintiff doing "all right." (I) continues to appear difficultly sleeping. (I) denies seeing PTV hallucinations. (I) reports feeling less depressed. (I) affect less blunted, mind calm and comprehendible. Term placed on (I) advancing to Level III.</p>	Scheduled Review Date: 12/01/99	Date of Review: 12/01/99
aff Members Present:	Wishy, U. Pinowitz, S. S. Scarce, M. Mohr		
aff Members Present:	Wishy, U. Pinowitz, S. S. Scarce, M. Mohr	Scheduled Review Date: 12/02/99	Date of Review: 12/02/99
Notes:	<p>(I) appears blunted, mood blunted. (I) denies if he is in halucinations. (I) denies depression despite affect. (I) nights sleeping "a couple of hours here and there" -- he defines that he doesn't sleep all night; (I) feels calmer and good. (I) denies all questions in monosyllabic form -- difficult to engage in conversation</p>		
aff Members Present:	Wishy, G. L. Jones, S. Scarce, M. Mohr	Scheduled Review Date: 1/3/00	Date of Review: 1/3/00
Notes:	<p>(I) appears blunted affect blunted. (I) anxiety during T. 1:00 am. (I) denies PTV hallucinations; (I) reporting mild delusions in public participation: (I) inpatient advancing to Level IV.</p>		
aff Members Present:	Wishy, S. Scarce, M. Mohr		
Inmate Name:	WOODS, Bruce		Inmate Number: 329-884

TREATMENT PLAN REVIEW

Notes:	<p>(1) deny blinks, mood depressed, though lessor than last year 11/8, (2) denies depression however. (3) denied seeing other at all hallucinations: (1) reports that he declined medications for outside medications due to child medication. (2) housed in seprate facil, awaiting reclassification see below. No specific ch.</p>	Scheduled Review Date:	1/3/2000	Date of Review:	1/24/2000
Members Present:	Robby, D. Pindutt, AD Mckay	Scheduled Review Date:	2/1/2000	Date of Review:	2/19/2000
Notes:	<p>(1) report mood fluctuating. (2) denies seeing or having friends denies depression or problems interacting with peers. Denies recent year friend issues w/ (2) and varying level III. (3) was informed of the need for him to participate in anger management class and to remain (4) TII. (5) agreed to this particular. No specific complaints voiced</p>	Scheduled Review Date:	2/1/2000	Date of Review:	2/26/2000
Members Present:	R. Rishby, S. M. J. O. A.	Scheduled Review Date:	2/1/2000	Date of Review:	2/26/2000
Notes:	<p>Effect brighter). Inmate Woods waiting for a transfer to Warren. Denies problems w/ others. State park is helping. Denies depression, ST, HT, sleep & appetite "ok". X (not taking sleeping pills)</p>	Scheduled Review Date:	2/1/2000	Date of Review:	2/26/2000
Members Present:	P. Nicastri RN, AD Just S. M.	Inmate Name:	WOODS, Bruce	Inmate Number:	329 - 889

TREATMENT PLAN REVIEW

Minutes: (I) Affect / missed laughter. (T) Sustained 'ah' /
Laughter: Diminished vomiting due to burst himself or others. Eating
And sleeping okay. (T) denies SI/bi Or All habitual vomiting.
(2) Vomited without noticing on how transfer it to another
Vomit - Habitual.

ff Members Present: S. G. L. S., O. Knoutt, H. J.

minutes: _____

Scheduled Review Date: _____

Date of Review: _____

RESULTS

Inmate Name:	Woods, B
Inmate Number:	329 859

WUOS 061-0001

TREATMENT PLAN REVIEW

Minutes: <u>I</u> is no longer on medication. <u>I</u> denies depressive symptoms. <u>I</u> participates only minimally in treatment with MHT and Psychiatrist. <u>I</u> maintains there is nothing wrong with him and wants to be DIC from caseload.	Scheduled Review Date: <u>8/12/00</u>	Date of Review: <u>8/17/00</u>
Staff Members Present: <u>Tina Demerle</u> <u>SSA</u> <u>S. Rajin MD</u> <u>X Wm</u> <u>329997</u>	Scheduled Review Date:	Date of Review:
Minutes: _____	_____	_____
Staff Members Present: _____	_____	_____
Minutes: _____	_____	_____
Staff Members Present: _____	_____	_____
Minutes: _____	_____	_____
Staff Members Present: _____	_____	_____
Inmate Name: _____	Inmate Number: _____	

Mental Health Level of Care Determination

Inmate Name:	Number:	Institution:	Date:
Woods	329-889	WCI	8/28/00

 Initial Annual Review Update

C1 Categorical (SMI)	<input type="checkbox"/> 290.XX Dementia	<input type="checkbox"/> 295.XX Schizophrenia	<input type="checkbox"/> 295.40 Schizoaffective D/O
	<input type="checkbox"/> 295.70 Schizoaffective	<input type="checkbox"/> 296.2X MDD Single, Severe	<input type="checkbox"/> 296.3X MDD, Recurrent
	<input type="checkbox"/> 296.XX Bipolar D/O	<input type="checkbox"/> 297.1 Delusional D/O	<input type="checkbox"/> 298.X Brief Psychotic or NOS
	<input type="checkbox"/> 318.0 Moderate MR		

C1 Functional (SMI)	<input type="checkbox"/> 296.XX Mood Disorders	<input type="checkbox"/> 300.XX Panic D/O	PLUS
	<input type="checkbox"/> 300.00 Anxiety D/O NOS	<input type="checkbox"/> 300.02 GAD	(One of the following within the past 2 years)
	<input type="checkbox"/> 300.3 OCD	<input type="checkbox"/> 300.4 Dysthymic D/O	<input type="checkbox"/> 2 Prior Psychiatric Hospitalizations
	<input type="checkbox"/> 309.81 PTSD	<input type="checkbox"/> 301.83 Borderline P.D.	<input type="checkbox"/> 1 OCF Hospitalization > 45 Days
		<input type="checkbox"/> RTU > 60 Days	

C2	<input type="checkbox"/> 291.X ETOH	<input type="checkbox"/> 292.X Substance Related D/O	<input type="checkbox"/> 293.X Psychosis or Mood D/O 2 nd Medical
	<input type="checkbox"/> 294.X Memory or Cognitive D/O 2 nd Medical or NOS	<input type="checkbox"/> 296.X Mood Disorder	<input type="checkbox"/> 300.XX Panic D/O
	<input type="checkbox"/> 300.00 Anxiety D/O NOS	<input type="checkbox"/> 300.02 GAD	<input type="checkbox"/> 300.3 OCD
	<input type="checkbox"/> 300.4 Dysthymic D/O	<input type="checkbox"/> 302.X Paraphilia on Meds	<input type="checkbox"/> 309.XX Adj. D/O on Meds
	<input type="checkbox"/> 309.81 PTSD	<input type="checkbox"/> 311 Depressive D/O NOS	<input type="checkbox"/> 301.83 Borderline PD

C3	<input type="checkbox"/> 300.XX Panic D/O	<input type="checkbox"/> 300.00 Anxiety D/O NOS	<input type="checkbox"/> 300.02 GAD
	<input type="checkbox"/> 300.3 OCD	<input type="checkbox"/> 300.4 Dysthymic D/O	<input type="checkbox"/> 301.XX Personally D/O
	<input type="checkbox"/> 302.X Paraphilia	<input type="checkbox"/> 307.8X Panic D/O with Psychology/Medical	<input type="checkbox"/> 308.X Acute Stress D/O
	<input checked="" type="checkbox"/> 309.XX Adjustment D/O	<input type="checkbox"/> 309.81 PTSD	<input type="checkbox"/> 311 Depressive D/O NOS
	<input type="checkbox"/> 312 Impulsive Control D/O		

N

No Mental Health Services Needed

SO

Sex Offender Services

Printed Name of Licensed Person Completing Review:

K. Washington, Ph.D.

Signature:

R. J. P. A.D.

Referral to Mental Health Services

Inmate name:	Number:	Date of Referral:
Woods	329-889	9/6/00
Job:	Lock:	Unit:
	3C	3C

 Routine ASAP Urgent

Reason for Referral:

(E) is asking to talk w/ Dr. Roje or someone else. Very irritated.

Referred by:	CO Walker (?)
Title:	Corrections Officer
	Phone Ext.: 3400

Response: (I) Seen 9/6/00.

Mental Health Staff Signature:	Date of Response:
	9/6/00
Supervisor Signature:	



Mental Health Services

Recommendation For Discharge From The Mental Health Caseload

Inmate Name: Woods Number: 329-889

All recommendations must be supported by documentation on Interdisciplinary Progress Notes.

Treatment Coordinator Recommendation:

The above named inmate has been evaluated, and recommendation is made to discharge this inmate from the mental health caseload.

Summary Statement in Support of Recommendation:

(1) diagnosis is adjustment D/O with depressed mood. Medication was discontinued 6/1/00 and (2) remains stable. (1) participation in treatment has been minimal and it appears he is receiving little to no benefit from mental health services. No 70 day follow up required.

Kimberly Denefee Social Worker II 9/6/00
Name Title Date

Psychiatric Consultation:

I concur with the above recommendation (Reduce to P1A Status)

I do not concur with the above recommendation

Comments:

*Doing fairly well S medication. Stable
pt requesting D/C from case load.*

S. Raju MD 9/12/00
Signature Date

Follow up: (70 days after Psychiatric Consultation)

This inmate may be discharged from the mental health caseload (Reduce to P1 Status)

This inmate should be maintained on the mental health caseload

Comments:

Name	Title	Date
------	-------	------

WOODS

329 - 889

Murphy JR

6/1/00 0920H

Prob. No.	Date:	6-1-00	Time:	9:15 AM
DC fail (pr noncompliant for a month)				

Ward RN Date Time

Signature: *S. K. Kuhn MD*

Ward RN Date Time

Signature: *S. K. Kuhn MD*

WOODS

329 - 889

Murphy JR

5/2/00 1135H

Prob. No.	Date:	5/2/00	Time:	12:45 PM
Review Hx & 2 Lm 3 Dmrtion				

Ward RN Date Time

Signature: *S. K. Kuhn MD*

Prob. No.	Date:	5/14/00	Time:	1:45 PM
Review Hx & 2 Lm 3 Dmrtion				

Ward RN Date Time
Run addressograph machine over patients name plate only

Drug Sensitivity				
Prob. No.	Date:	Time: 7/2/02		
<i>for 6/20/00 1135H 3 Dmrtion 1059 1059</i>				

Ward RN Date Time

Signature:

DOCTOR'S ORDERS

DOCTOR'S ORDERS

2

DOCTOR'S ORDERS

DOCTOR'S ORDERS

4